# Theme 3: Expanding Beneficiaries' Choices and Availability of Managed Care Options

**Summary:** The 1990s were marked by dramatic changes in the health insurance marketplace. More recently, as a result of consumers' demand for more flexibility and choice, there has been a shift in managed care enrollment toward less restrictive managed care delivery systems such as Preferred Provider Organizations (PPOs) and Point of Service (POS) plans. CMS is working to develop a variety of flexible health plan demonstrations to reflect changes in the health care market, test new ideas for improved services, and develop new alternatives to traditional fee-for-service Medicare.



## Sub-Zero Premium (BIPA 606) M+C Plan Evaluation

**Project No:** 500-95-0057/06c
**Project Officer:** Victor McVicker
**Period:** January, 2002 to September, 2003
**Funding:** $249,307
**Principal Investigator:** Mary Laschober
**Award:** Contract
**Awardee:** BearingPoint
1676 International Drive
McLean, VA 22102-4828

**Description:** The contractor conducted a limited evaluation of the new "Sub-Zero Premium" plans being offered to Medicare beneficiaries by M+C organizations in CY2003. Section 606 of BIPA amended the Social Security Act to permit M+C organizations to offer a reduction of the Medicare standard Part B premium as an additional benefit. This provision took effect January 1, 2003. In CY2003, 6 M+C organizations were offering in 2 States (NY and FL) 10 plans with this benefit.

The purpose of this limited evaluation was to learn from beneficiaries why they enrolled in these new M+C plans and what their initial experience was. In addition, we learned from the plans their reasons for offering these plans, their expectations, and their experiences. The contractor had telephone discussions with key individuals at the sub-zero premium plans, reviewed and provided a description of the marketing materials used with this product, and conducted 10 focus group meetings at the two areas.

**Status:** BearingPoint submitted a draft final report for CMS review. The key findings from this report are the following:

- Compared with other M+C plans offered in the counties under study, the sub-zero premium product require higher co-payments and offer less generous supplemental benefits, including no or limited prescription drug coverage.
- Some Florida-based beneficiaries and low-income beneficiaries cited the premium reduction as a reason for choosing their sub-zero premium plan. For most beneficiaries either currently or previously enrolled in a sub-zero premium plan, though, the overwhelming driver of their health plan choice was the participation of their personal physician(s) in the plan.
- Enrollees in Florida seemed to view the sub-zero premium plans as "interim" plans for healthy aged people until they develop more serious health concerns. For such people, the almost $60 per month in savings is a valuable plan benefit.
- In New York, where the reduction was $20 to $30 per month, enrollees considered the reduction insignificant and had not given it much consideration. ■

## Medicare Choices Demonstration: Verification of Encounter Data

**Project No:** 500-95-0050/02
**Project Officer:** Victor McVicker
**Period:** September, 1997 to March, 2003
**Funding:** $2,640,401
**Principal Investigator:** Marjorie Hatzman
**Award:** Task Order
**Awardee:** Medstat Group (DC)
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512

**Description:** This project ensures that accurate and comprehensive encounter data are reported in the Medicare Choices Demonstration. It assesses the health plan information systems' capabilities, the overall

reasonableness of the encounter data against benchmarks, and the validity of the encounter data against medical record information. On a quarterly basis and for each of the plans participating in the demonstration, a sample of enrollees is selected and medical records are examined to determine whether the information in the encounters (pseudo-claims) reflects what is in the medical record. Using the medical record, the project assesses the timeliness of the encounter data, the validity of the codes in the encounter data, and the completeness of the information.

**Status:** The data are being finalized to make the risk-adjusted payments. The Medicare Choices Demonstration plans have had considerable difficulty supplying encounter data that are in the correct format and that contain all the required information to the FIs and carriers. As a result, most of Medstat's efforts have been directed at providing technical assistance to the plans rather than performing the medical record reviews as originally planned. ■



### Community Nursing Organization Demonstrations: Final Report to Congress

**Project No:** 500-95-0062/10
**Project Officer:** Victor McVicker
**Period:** November, 1999 to June, 2003
**Funding:** $343,602
**Principal Investigator:** Austin Frakt, Ph.D.
**Award:** Contract
**Awardee:** Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138

**Description:** This report to Congress was required under Section 632 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 to evaluate the Community Nursing Organization (CNO) demonstration. An earlier evaluation was conducted of the CNO demonstration that covered the operation of the demonstration from January 1, 1994, to June 30, 1997 (Phase I). The demonstration assessed the impact of providing a specified package of community-based services, in conjunction with case management, under a capitated payment methodology. This earlier evaluation found that, overall, the treatment and control groups did not differ significantly in health status. However, when total expenditures for the two groups were compared, the CNO groups proved to be significantly more costly—from $25 per member per month to $75 per member per month more than the control group. To investigate whether the results might change in the long run, BIPA mandated a preliminary report to evaluate the demonstration for the period beginning July 1, 1997, and ending December 31, 1999 (Phase II). The key finding of this evaluation was that the results have not changed: the provision of services by the CNO groups on a capitated basis continue to be more expensive than providing the same Medicare-covered services to the control groups on a fee-for-service (FFS) basis. This final report to Congress adds 7 more months to the preliminary evaluation concluding in July 2000.

**Status:** This final report to Congress was submitted to the U.S. Congress on May 12, 2003. The key finding of the final evaluation is that the provision of services by the CNO groups on a capitated basis proved to be more expensive than providing the same Medicare-covered services on an FFS basis. Thus, the results did not change by adding the 7 months of experience in 2000. ■

### Evaluation of the M+C Alternative Payment Demonstration

**Project No:** 500-95-0057/06b
**Project Officer:** Victor McVicker
**Period:** January, 2002 to September, 2004
**Funding:** $683,363
**Principal Investigator:** Jim Moser
**Award:** Contract
**Awardee:** BearingPoint
1676 International Drive
McLean, VA 22102-4828

**Description:** The Medicare+Choice (M+C) alternative payment demonstration was designed to address the declining number of M+C organizations (M+COs) serving Medicare beneficiaries, specifically in areas where only one M+CO is serving the area. The demonstration tests the feasibility of using alternative payment approaches such as risk-sharing or reinsurance models in the M+C program. This evaluation is examining the experience of the six M+COs that began participating in the demonstration on January 1, 2002, and one M+CO that began on June 1, 2002. One of these organizations is using a reinsurance model while the other six organizations are using risk sharing around a targeted medical expense. The evaluation is exploring whether these payment arrangements increased plan revenues and the impacts on the profile of beneficiaries enrolled in the plans and the benefits available to them.

**Status:** The draft interim report, which covers the first year of the demonstration (2002), will be submitted to CMS in January. ■

### Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration

**Project No:** 500-00-0024/05
**Project Officer:** Victor McVicker
**Period:** September, 2002 to September, 2007
**Funding:** $2,545,139
**Principal Investigators:** Leslie Greenwald and Gregory Pope
**Award:** Task Order
**Awardee:** Research Triangle Institute (NC)
3040 Cornwallis Road
PO Box 12194
Research Triangle Park, NC 27709-2194

**Description:** The purpose of this project is to evaluate the Medicare Preferred Provider Organization (PPO) demonstration. This comprehensive evaluation includes a case study component to examine issues pertaining to the implementation and operational experiences of the PPOs as well as statistical analyses of secondary data, including individual-level data, to examine issues of biased selection and impacts on the use and cost of services. Primary data are being collected through site visits to participating plans and beneficiary surveys.

**Status:** The site visits have been completed, and each organization has reviewed its respective case study report. The contractor has submitted a draft report of case studies of 16 organizations representing 31 different demonstration contracts. This case study report focuses on the following areas: reasons for participating in the PPO demonstration, design and characteristics of the PPO product, marketing of the PPO product to Medicare beneficiaries, provider issues, and MCO perceptions and comments regarding the PPO demonstration. ■

## MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) DEMONSTRATION (PHASE II)

Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare+Choice (M+C) program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices by increasing incentives for M+C organizations to enter the market and offer PPO products.

This demonstration program is modeled after the PPO coverage available in the commercial market. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost-sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive toward seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but four of the participating organizations currently have a risk-sharing arrangement with CMS.

There are currently 35 PPO demonstration plans in 22 States for the 2004 contract year. Total enrollment in the demonstration products is 94,739 as of April 1, 2004.

**Status:** Currently operational; demonstration will terminate December 2005. ■

### Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

**Project No:** 95-W-00118/09
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Health Net Life Insurance Company
2800 North 44th Street, Suite 900
Phoenix, AZ 85008-1553

### Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

**Project No:** 95-W-00126/09
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Pacificare of Arizona, Inc.
4601 East Hilton Avenue
Phoenix, AZ 85034

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00119/09
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Health Net Life Insurance Company
21281 Burbank Boulevard
Building B
Woodland Hills, CA 91367

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00110/01
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Aetna Health Inc.
Mailstop RT11
1000 Farmington Avenue
Hartford, CT 06156

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00125/05
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** OSF Health Plans, Inc.
7915 North Hale Avenue, Suite D
Peoria, IL 61615

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00109/0**5**
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Advantage Health Solutions, Inc.
9490 Priority Way, West Drive
Indianapolis, IN 46240

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00111/05
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Anthem Health Plans of KY, Inc.,
Community Insurance Company
220 Virginia Avenue
Indianapolis, IN 46204

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00123/04
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Humana Insurance Company
500 West Main Street
Louisville, KY 40202

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00128/06
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Tenet Choices, Inc.
200 West Esplanade Avenue
Suite 600
Kenner, LA 70065

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00129/05
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** United Healthcare Insurance Company
9900 Bren Road East
Mail Route MN008-T500
Minnetonka, MN 55343

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00113/07
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Coventry Health and Life Insurance Company
111 Corporate Office Drive
Suite 400
Earth City, MO 63045

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00114/07
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Coventry Health and Life Insurance Company
8320 Ward Parkway
Kansas City, MO 64114

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00122/02
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Horizon Healthcare of New Jersey, Inc.
3 Penn Plaza East
Newark, NJ 07105-2200

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00127/09
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Pacificare of Nevada, Inc.
700 East Warm Springs Road
Las Vegas, NV 98119

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00117/02
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Group Health Inc.
441 Ninth Avenue
New York, NY 10001

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00120/02
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** HealthNow New York, Inc.
1901 Main Street
Buffalo, NY 14208

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00124/02
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Managed Health Inc.
25 Broadway, 9th Floor
New York, NY 10004

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** W-95-00116/03
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Health Assurance Pennsylvania, Inc.
3721 TecPort Drive
PO Box 67103
Harrisburg, PA 17106-7103

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00112/04
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Cariten Insurance Company
1420 Centerpoint Boulevard
Knoxville, TN 37932

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00121/04
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Health Spring Inc.
44 Vantage Way, Suite 300
Nashville, TN 37228

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00130/03
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** University of Washington School of Nursing
SC-72
Seattle, WA 98195

**Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)**

**Project No:** 95-W-00115/03
**Project Officer:** Deborah VanHoven
**Period:** January, 2003 to December, 2005
**Funding:** $100,000
**Principal Investigator:**
**Award:** Grant
**Awardee:** Coventry Health and Life Insurance Company
500 Virginia Street East
PO Box 1711
Charleston, WV 25326

## MEDICARE+CHOICE ALTERNATIVE PAYMENT (PHASE I) DEMONSTRATION

With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled steadily declined from a high of 18 percent in 1999. This trend of plans exiting the market continued for 2002. The M+C Alternative Payment Demonstration was designed

to take immediate action to test whether alternatives to the current M+C payment systems, in particular various risk-sharing and reinsurance arrangements, could be used to encourage M+COs to remain in the M+C program. The demonstration was initially scheduled to last for 2 years (2002 and 2003) but was extended an additional year for 2004.

Six new M+C plans were effective under this demonstration on January 1, 2002. They included one PPO (Independence Blue Cross), one private fee-for-service plan (Humana in DuPage County, Illinois), and one employer group only program incorporating two health plans and three contracts sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh plan sponsored by United Healthcare of Wisconsin was added to the demonstration. M-Care, which offered a plan in 2002 in Livingston and Washtenaw counties in Michigan, dropped out of the demonstration and terminated its M+C plan effective January 1, 2003. At the request of several plans, a decision was made in late 2003 to allow the remaining plans the option of extending the demonstration for an additional year in 2004. Humana, Pacificare, Independence Blue Cross, and the Wheeling-Pittsburgh plans will be extended. Anthem and United Healthcare of Wisconsin will terminate their demonstration plans but continue to offer a regular M+C plan in these counties. As of March 1, 2004, the remaining active plans had just fewer than 40,000 members.

**Status:** Currently active; demonstration will terminate 12/31/2004. ■

### Medicare+Choice Alternative Payment (Phase I) Demonstration

**Project No:** 95-W-00104/09
**Project Officer:** Jody Blatt
**Period:** January, 2002 to December, 2004
**Funding:** $0
**Principal Investigator:**
**Award:** Waiver-Only Project
**Awardee:** Pacificare Health Systems, Inc.
3120 Lake Center Drive
Santa Ana, CA 92704

### Medicare+Choice Alternative Payment (Phase I) Demonstration

**Project No:** 95-W-00105/04
**Project Officer:** Jody Blatt
**Period:** January, 2002 to December, 2004
**Funding:** $0
**Principal Investigator:** Douglas R. Carlisle
**Award:** Waiver-Only Project
**Awardee:** Employers Health Insurance Company
500 West Main Street, 7th Floor
Louisville, KY 40201

### Medicare+Choice Alternative Payment (Phase I) Demonstration

**Project No:** 95-W-00107/03
**Project Officer:** Jody Blatt
**Period:** January, 2002 to December, 2004
**Funding:** $0
**Principal Investigator:** Mary Xlinos
**Award:** Waiver-Only Project
**Awardee:** Coventry Health Care, Inc.
6705 Rockledge Drive
Bethesda, MD 20817

### Actuarial Assessment of PACE Enrollment Characteristics in Developing Capitated Payments

**Project No:** 500-95-0061/09
**Project Officer:** Frederick Thomas
**Period:** September, 2000 to May, 2004
**Funding:** $120,460
**Principal Investigator:** James Robinson
**Award:** Task Order
**Awardee:** University of Wisconsin, Madison
750 University Avenue
Madison, WI 53706

**Description:** The BBA (1997) requires the PACE program to be paid using the risk-adjustment method developed for Medicare+Choice programs, but adjusted for factors specific to the PACE program. PACE is expected to differ from M+C plans in a number of attributes: enrollment size, group bias, dual Medicaid capitation, and mortality rates. An actuarial assessment is needed to explore the risk characteristics related with these factors and to formulate options that use this information in a capitated payment system.

**Status:** A final report is being reviewed. ■

### Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) as a Permanent Program and of a For-Profit Demonstration

**Project No:** 500-00-0033/01
**Project Officer:** Frederick Thomas
**Period:** September, 2001 to September, 2006
**Funding:** $819,772
**Principal Investigator:** Valerie Cheh
**Award:** Task Order
**Awardee:** Mathematica Policy Research (Princeton)
600 Alexander Park
PO Box 2393
Princeton, NJ 08543-2393

**Description:** This is an evaluation of the Program for All-Inclusive Care for the Elderly (PACE) as a permanent Medicare program and as a State option under Medicaid. This project evaluates PACE in terms of site attributes, patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data and other comparable populations. This project expands on the foundations laid in the previous evaluations of PACE by predicting costs beyond the first year of enrollment and assessing the impact of higher end-of-life costs and long-term nursing home care.

**Status:** The evaluation is ongoing. Fieldwork is expected to begin in fall 2004. ■

### Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance

**Project No:** 500-96-0004/02
**Project Officer:** Mary Wheeler
**Period:** September, 1990 to September, 2002
**Funding:** $3,203,917
**Principal Investigator:** Peter Shaughnessy
**Award:** Task Order
**Awardee:** Center for Health Services Research, University of Colorado
1355 South Colorado Boulevard
Suite 706
Denver, CO 80222

**Description:** The purpose of this project is to develop a core data set that is the foundation for an outcome-based quality improvement (OBQI) system for the Program of All-Inclusive Care for the Elderly (PACE) program. The OBQI system consists of two phases during which the PACE sites complete the data instrument that contains items for outcome measurement and risk adjustment at specific time intervals. Using the data collected in the first phase, site-level reports can be produced summarizing the outcome measures. By comparing site-level case-mix adjusted outcome reports to other PACE site outcome reports and to the site's previous outcome reports from earlier time periods, the site, CMS, and the State Medicaid agencies are able to identify areas that require further examination due to inferior (or perhaps superior) outcomes. In the second phase, the sites take a closer look at why and how the specific outcomes are achieved and make recommendations for improvements in the case of poor (or perhaps superior) outcomes.

**Status:** Significant progress has been made in the development of outcome indicators for PACE. The OBQI contract was modified in October 1999, which expanded the period of performance and increased the level of effort to support the development of a Core Comprehensive Assessment (COCOA) instrument for PACE providers. Although this change in the timeline will delay the OBQI component, the burden of data collection on the PACE sites will be decreased. ■

### Promoting State Interest in Identifying PACE Markets

**Project No:** 500-03-0048
**Project Officer:** Frederick Thomas
**Period:** September, 2003 to September, 2004
**Funding:** $199,970
**Principal Investigator:** Peter Fitzgerald
**Award:** Contract
**Awardee:** National Pace Association
801 North Fairfax
Alexandria, VA 22314

**Description:** Since the Balanced Budget Act of 1997 made the Program of All-Inclusive Care for the Elderly (PACE) a permanent Medicare Program, there has been little program expansion, and the number of PACE sites is still at the 1999 level. Since PACE is a joint Medicaid program, expansion requires support by State Medicaid programs. With State budgets strained, the basic work to assess the feasibility of implementing PACE programs has been overlooked by some States. This contract will fund up to four State-specific studies to determine PACE feasibility, as well as potential impediments to PACE expansion. The goal is to promote new state interest and identify potential providers interested in PACE program development.

**Status:** Work is progressing, with the process started to identify participating States and the feasibility study protocol being developed. ■

### Pilot Test and Analysis of the Medicare Health Survey for Program for All-Inclusive Care for the Elderly (PACE) and EverCare (MHSPE)

**Project No:** 500-00-0030/03
**Project Officer:** Ronald Lambert
**Period:** September, 2001 to September, 2004
**Funding:** $1,033,894
**Principal Investigator:** Edith Walsh
**Award:** Task Order
**Awardee:** Research Triangle Institute
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

**Description:** The purpose of this project is to test and implement a variant of the Health Outcome Survey (HOS) for organizations that serve special populations. In Phase I, the feasibility of implementing this survey for the Program of All-Inclusive Care for the Elderly (PACE) was demonstrated. In Phase II, the PACE Health Survey was implemented for the PACE Program. The survey findings will support the implementation of frailty-adjusted Medicare capitation payments to PACE organizations.

**Status:** During 2003, the PACE Health Survey was administered to enrollees of 26 PACE organizations. The overall response rate was 77 percent, with plan response rates ranging from 62 percent to 92 percent. These response rates are significantly better than the previous HOS response rates for PACE. The functional impairment information collected by the PACE Health Survey was used to determine the frailty adjuster for each PACE organization for the purposes of Medicare payment in 2004. ■

### Second-Generation Social Health Maintenance Organization Demonstration: Nevada

**Project No:** 95-W-90503/09
**Project Officer:** Thomas Theis
**Period:** November, 1996 to December, 2004
**Funding:** $0
**Principal Investigator:** Bonnie Hillegass
**Award:** Waiver-Only Project
**Awardee:** Health Plan of Nevada, Inc.
PO Box 15645
Las Vegas, NV 89114-5645

**Description:** The purpose of this second-generation social health maintenance organization (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The S/HMO-II model provides an opportunity to test models of care focusing on geriatrics. The Health Plan of Nevada (HPN) is one of six organizations originally selected to participate in the project.

**Status:** The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 will be determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjustor employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. HPN is the only S/HMO II model operational site in the demonstration. HPN began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 2004 was over 48,000 members.

The project's final Report to Congress was released to Congress by the Secretary of Health and Human Services in February 2003. The purpose of this report is to present an analysis of the S/HMO II model. ■

### Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

**Project No:** 95-P-09101/02
**Project Officer:** Thomas Theis
**Period:** August, 1984 to December, 2004
**Funding:** $0
**Principal Investigator:** Eli Feldman
**Award:** Waiver-Only Project
**Awardee:** Elderplan, Inc.
6323 Seventh Avenue
Brooklyn, NY 11220

**Description:** This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under

the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Elderplan is one of the long-term care provider sites that developed and added an acute-care service component.

**Status:** Elderplan implemented its service delivery network in March 1985. Elderplan uses both Medicare and Medicaid waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001, making the end date July 2003.

CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 will be determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjustor employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk-adjustment system with the additional frailty adjustment. ■

### Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research

**Project No:** 95-P-09103/00
**Project Officer:** Thomas Theis
**Period:** August, 1984 to December, 2004
**Funding:** $0
**Principal Investigator:** Lucy Nonnenkamp
**Award:** Waiver-Only Project
**Awardee:** Kaiser Permanente Center for Health Research
2701 NW Vaughn Street, Suite 160
Portland, OR 97210

**Description:** This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services were provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate—two were health maintenance organizations (HMOs) that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Kaiser Permanente Center for Health Research (doing business as Senior Advantage II) is one of the HMO sites that developed and added a long-term care component to its service package.

**Status:** Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II used Medicare waivers only. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001, making the end date July 2003.

CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 will be determined by the CMS-Hierarchical Condition Category risk adjustment model, with a frailty adjustor employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk-adjustment system with the additional frailty adjustment. ■

### Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan

**Project No:** 95-P-09104/09
**Project Officer:** Thomas Theis
**Period:** August, 1984 to December, 2004
**Funding:** $0
**Principal Investigator:** Timothy C. Schwab
**Award:** Waiver-Only Project
**Awardee:** SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
PO Box 22616
Long Beach, CA 90801-5616

**Description:** This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO

integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. SCAN Health Plan is one of the long-term care provider sites that developed and added an acute-care service component.

**Status:** SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 will be determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjustor employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. ■

## End Stage Renal Disease (ESRD) Managed Care Demonstration: Health Options

**Project No:** 95-C-90692/04
**Project Officer:** Sid Mazumdar
**Period:** September, 1996 to December, 2005
**Funding:** $0
**Principal Investigator:** Jeremy Ginder
**Award:** Cooperative Agreement
**Awardee:** Advanced Renal Options
8400 NW 33rd Street, 4th Floor
Miami, FL 33122

**Description:** The original demonstration program, Advanced Renal Options, tested whether open enrollment of End Stage Renal Disease (ESRD) patients in managed care was feasible with a capitation rate adjusted for age, treatment status, and cause of renal failure, and additional payment made for extra benefits.

**Status:** As of April 2004, there were 269 beneficiaries enrolled. Data collection for evaluation purposes ended May 31, 2001, at the conclusion of the mandated 3-year period. Waivers were renewed for the period June 1, 2001, through December 31, 2002, for residual demonstration enrollees to continue to receive the extra benefits, with CMS paying an unadjusted capitation rate based on the demonstration rate. Waivers were renewed again for the period January 1, 2003–December 31, 2005. ■

## Data Collection for Second Generation S/HMO

**Project No:** 500-96-0005/02
**Project Officers:** Pauline Karikari-Martin and Thomas Theis
**Period:** November, 1996 to December, 2004
**Funding:** $8,978,005
**Principal Investigator:** Lisa Maria Alecxih
**Award:** Task Order
**Awardee:** Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

**Description:** This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. The work was done by Mathematica Policy Research under a subcontract. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. The information gathered served three primary functions: baseline and follow-up data for the analyses, clinical information to the participating S/HMO-II sites for care planning, and data for risk-adjustment and payment. In addition, this project supports two congressionally mandated reports to Congress, an S/HMO Transition Report to Congress and a Final Report to Congress on the S/HMO II project. While multiple sites were originally planned for this demonstration, only one, the Health Plan of Nevada, actually implemented an S/HMO II plan. The evaluation was designed to assess the impact of the S/HMO II by comparing it with regular Medicare+Choice sites using measures of utilization, quality of care, and changes in participant health status over time.

**Status:** The reports to Congress have been prepared. The S/HMO Transition Report was released to Congress in February 2001. The second report to Congress, a Final Report to Congress on the S/HMO II Project, was released in February 2003. ■

### Refinement of Risk Adjustment for Special Populations

**Project No:** 500-99-0038
**Project Officer:** Ronald Lambert
**Period:** August, 2002 to July, 2004
**Funding:** $399,740
**Principal Investigator:** Gregory Pope
**Award:** Contract
**Awardee:** Research Triangle Institute
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

**Description:** This project will review and evaluate potential risk adjusters and develop a preliminary payment approach for frail populations. One of the purposes of this contract modification is to refine and further develop frailty adjustment. In 2000, CMS implemented a risk adjustment methodology that uses hospital inpatient diagnoses and pays Medicare+Choice (M+C) organizations a blend of 10 percent of the risk adjustment amount and 90 percent of the previous demographic payment amount. The payment approaches under consideration involve the application of a frailty adjuster in conjunction with the inpatient and ambulatory model that will be used for M+C organizations in 2004.

**Status:** CMS is considering implementing frailty adjustment for demonstrations and PACE in 2004. Prior to implementation, CMS will be sharing information with the demonstrations, PACE, and other interested parties and pursuing clearance through the Office of Management and Budget and the Department of Health and Human Services. Refinements and further development will be necessary to reflect more recent research or changes in policy direction. This is a modification to existing contract with Health Economics Research (HER, # 500-99-0038). ■

### Refinements to Medicare Diagnostic Cost Group (DCG) Risk-Adjustment Models

**Project No:** 500-00-0030/04
**Project Officer:** Melvin Ingber
**Period:** September, 2002 to September, 2004
**Funding:** $568,038
**Principal Investigator:** Gregory Pope
**Award:** Task Order
**Awardee:** Research Triangle Institute
411 Waverly Oaks Road, Suite 330
Waltham, MA 02452-8414

**Description:** A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations was developed under contract with CMS (#500-92-0020 Task Order 6) and were then further improved (#500-95-0048 Task Order 3). This task order will test the model for use in special populations to develop satisfactory payment for plans that enroll beneficiaries selectively based on their medical, functional, or institutional condition. The DCG-based models are designed to use demographic and diagnostic information to project expenditures and to provide factors that could be used to multiply the ratebook amounts instead of the demographic factors currently used.

Further work is to be done on a concurrent model and on an institutional model using a larger sample. The ICD-9 tables will be updated to reflect coding changes to keep the model responsive to new codes.

**Status:** The early work has been completed and the latter projects are in process. ■

### Evaluation of the Medical Savings Account Demonstration

**Project No:** 500-95-0057/06
**Project Officer:** Victor McVicker
**Period:** September, 1998 to September, 2004
**Funding:** $404,640
**Principal Investigator:** Kenneth Cahill
**Award:** Task Order
**Awardee:** BearingPoint
1676 International Drive
McLean,VA 22102-4828

**Description:** This project evaluates the Medical Savings Account (MSA) Demonstration. It compares the experience of MSA enrollees with other Medicare beneficiaries.

**Status:** No insurers have elected to participate in the MSA demonstration. A report to Congress is being reviewed within CMS. ■

### Modeling M+C Standardized Benefit Packages in Local Markets

**Project No:** 500-95-0057/06a
**Project Officer:** Victor McVicker
**Period:** January, 2002 to September, 2003
**Funding:** $184,688
**Principal Investigator:** Mary Laschober
**Award:** Contract
**Awardee:** BearingPoint
1676 International Drive
McLean,VA 22102-4828

**Description:** The purpose of this project is to explore the feasibility of developing M+C standardized core benefit package and standardized add-on benefit options

that plans can choose when designing benefit packages to offer in their service area. The design of the proposed packages is based on the current range of plan offerings in local Medicare markets and on the experiences of other Federal, State, and private organizations with developing defined benefit packages. Information on the M+C benefit package was supplemented by key informant interviews and a focused literature review. The proposed packages could be used in a competitive model for Medicare (similar to FEHBP) that increases choices available to beneficiaries.

**Status:** BearingPoint has submitted a draft final report for CMS review. This report proposes for Medicare three model core benefit packages and four riders (with two options each) resulting in 240 combinations of core and riders that health plans could make available to beneficiaries. For each of the core benefit packages, this report provides the estimated annual cost for plan benefits and the amount paid by the beneficiary as out-of-pocket expenditures, as well as the total paid by the plan and the beneficiary. The report also discusses the advantages and disadvantages of standardization and the alternatives to full standardization. ■